Gender Inequity in Canadian Rheumatology

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The gender diversity of the Canadian rheumatology workforce has significantly improved over the last 25 years. In 1995, females accounted for less than one third of rheumatologists. Parity was reached in 2015, with an upward trajectory since then.[1] Unfortunately, however, there are many aspects of gender equality that have yet to be achieved. Consistent with other specialties, female rheumatologists earn less,[2] advance more slowly in their careers,[3] and face higher risks of burnout than their male peers.[4] While there are many possible reasons for these disparities, gender bias tends to begin early in the training of physicians. Considering that only 13% of Canada's orthopaedic surgery workforce is female,[5] one could argue that Canada's rheumatology workforce achieved faster parity in gender composition than other specialties as a consequence of the "hidden medical curriculum" that both subtly and overtly encourages women trainees to enter specific, "softer" and often lower-paid specialties. This systemic bias often extends beyond medical school, resulting in discrimination in career opportunities related to hiring, career advancement, clinical care arrangements, referral patterns; mechanisms used to pay physicians including payment models and fee schedules; and societal structures more broadly.[6] In general, women in medicine remain underrepresented in areas like leadership positions,[7] journal editorial boards,[8] and first or senior journal authorship positions.[9-11] They also receive fewer speaker invitations at medical conferences,[12] have lower grant and personnel award success rates,[13] receive lower industry payments,[14] progress more slowly in academic productivity and career advancement,[7] receive lower teaching evaluation scores,[15] are less likely to match to a surgical specialty in residency,[16] and are more likely to experience sexism and sexual harassment during medical school and within their workplace.[17,18]

Recently, greater attention is being placed on the gender pay gap in medicine. An important systemic driver that perpetuates pay inequity experienced by female physicians is the current physician fee-for-service (FFS) remuneration system, which rewards procedural tasks and volume of services over quality of care. Payment models that reward seeing more patients in less time tend to disadvantage female physicians who tend to spend more time with their patients.[19,20] There is also a growing body of evidence that female physicians have more effective communication styles and stronger patient-physician partnerships,[21,22] focus more on preventive health services,[21,23-25] and provide more guideline-concordant care,[24,26,27] which all may be a result of spending more time with their patients. Referral bias towards female specialists[28] and different patient expectations of female physicians[29] can also contribute to female physicians needing to spend more time with their patients and thus contributing to the gender pay gap inherent in the current FFS system. Both the Canadian and American rheumatology workforce surveys, and a recent study of Ontario rheumatologists' FFS billing claims, have reported that, on average, female rheumatologists see fewer patients than their male counterparts, resulting in lower remuneration (median difference of CAD $46,000–102,000 annually).[2,30,31] This gender pay gap in rheumatology cannot simply be explained by women working less, but rather by different practice styles and other factors.

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As gender equity means fairness of treatment for men and women according to their respective needs, in order to achieve gender equity in pay, it would be unfair to place unnecessary expectations on women to simply increase patient volumes, in the same sense that it would be unfair to expect male rheumatologists to lower their patient volumes in order to close the gender pay gap. Moreover, considering the high overhead of running a practice and the lack of funding support for allied health providers (who have been shown to increase practice efficiency, and patient volumes[32-34]), the current FFS remuneration system will continue to exacerbate the gender pay gap in rheumatology if male rheumatologists are more able to fund larger care teams through their higher earnings. While it is true that larger practices have higher operating expenses which impact the net take-home income of physicians (and we

currently do not have data on incomes or operating expenses of Canadian rheumatologists to fully quantify the gender wage gap) even small gender-based pay gaps are associated with substantial differences in lifetime wealth and retirement security.[35]

Further study is needed into identifying all gender disparities (and solutions) affecting rheumatologists, but immediate action is needed in order to help close the gender pay gap in rheumatology. Detailed actions that various stakeholders can take to close the gender pay gap in Canadian medicine have recently been proposed which address medical curriculum, transparent reporting of physician payments and hiring and promotion practices, and other strategies such as centralized referral systems and improving parental leave programs.[6] These actions must include (1) a re-evaluation of pay schedules to rectify gender-based inequities such as the issue of relativity of earnings across various medical and surgical specialties; (2) advocacy for reform to payment schedules, such as time modifiers or complexity add-on codes to more fairly compensate physicians who see patients with challenging conditions and require more time per visit; (3) alternative payment models such as capitation and salary to avoid some of the inequities; and (4) funding to support allied health providers to enhance rheumatology clinical service capacity. We also need to better understand the needs of female rheumatologists to support their clinical capacity to care for their patients. Practice volumes are not a substitute for quality of care and we need to strive towards value over volume. However, we must also remain cognizant that volume of services of the overall workforce remains important (as increasing feminization of Canada's rheumatology workforce may negatively impede access for patients). Thus, it is equally important that population needs are being met and efforts continue with the adoption of alternative models of care to increase capacity. After all, rheumatology patients are disproportionately female, and they are also experiencing gender inequities in timely care.

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